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In The

Supreme Court of the United States

October Term, 1998

ADMINISTRATIVE COMMITTEE, WAL-MART STORES, INC. ASSOCIATES HEALTH AND WELFARE PLAN,

Petitioner,

vs.

KIMBERLY SPECIALE,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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STATEMENT OF THE CASE

On February 18, 1992, the Respondent, Kimberly Speciale, suffered injuries as the result of an auto accident. Speciale's medical expenses totalled approximately $70,000, with $54,015.07 of that amount being paid through an ERISA benefit plan administered by the Petitioner, Administrative Committee of Wal-Mart Stores, Inc. Associates Health and Welfare Plan. Many of the remaining unpaid providers filed liens pursuant to Illinois law. The underlying tort lawsuit was filed in state court in Kane County, Illinois and was settled between the parties for $45,000, of the $50,000 in available insurance coverage. Because the total claimed liens exceeded not only Speciale's expected net recovery, but even the gross recovery, Speciale then, as a part of and under the caption of the state court case, filed a Motion to Adjudicate Liens, all liens, filed on the state court case. The Petitioner, Administrative Committee of Wal-Mart Stores, Inc. Associates Health and Welfare Plan then removed the action to Federal Court.

The District Court initially denied Speciale's Motion to Remand and the Plan's Motion for Summary Judgment and decided the case on hearing briefs. The District Court, in denying the Motion for Summary Judgment, raised the possibility of the application of the "make whole" rule and Speciale, in her hearing brief, noted that if the court chose to apply the "make whole" rule, the Plan would surely recover nothing. Speciale's primary focus and argument has always remained on the issue of preemption. The Plan, as subrogee or reimbursee, cannot have rights to settlement funds greater than Speciale's and until that amount is determined, the Plan has no basis to assert its interpretations of plan language. The allocation of funds in the state court tort case is a function of the state court and those proceedings are not removable to federal court.

The District Court found that the Plan was entitled to the full amount of the settlement less a reasonable Attorney's fee, leaving the other lienholders and unpaid providers, totalling approximately $16,000, with no settlement proceeds. Speciale filed her appeal, the Plan did not. The Seventh Circuit reversed the District Court's judgment and reversed the denial of Speciale's Motion to Remand. The Seventh Circuit held that the Motion to Adjudicate was an action to apportion funds under state law and did not subject the matter to federal jurisdiction.

REASONS FOR DENYING THE WRIT

Subrogation issues in tort cases can often be more difficult than the case itself. Many times tort recoveries are compromised, due to difficult liability or inadequate liability insurance coverage for the damages. Circumstances in which distribution of funds in state tort cases require court intervention have become increasingly common; many liens can attach to limited funds and an invocation of the court's power regarding liens is even made prior to, and as part of, the settlement process itself to determine priority, applicability and extent. Those claims on the proceeds are an integral part of the case itself. ERISA plans usually require subrogation and/or reimbursement in a monolithic inflexible fashion, but rarely participate in the process of recovery, choosing instead to rely on the beneficiary or attorney to contact them in the end. At the end, plaintiffs' net recoveries are affected by many factors beyond their control. Speciale never raised the issue of the "make whole" rule. It is not the rule in Illinois state cases and was not part of the original Motion to Adjudicate Liens. The District Court raised its possible application in denying the Plan's Motion for Summary Judgment. The issue was prompted by the District Court's concern that it would seem to be inequitable to uphold the Plan's position that it receive the entire settlement, which it did nothing to procure, and leave the Plaintiff with $16,000 in unpaid

medical expense and an unpaid lawyer. In her hearing brief, Speciale acknowledged that its application would benefit her, but, the brief primarily sought confirmation of the liens and a prioritization that placed the Plan in the shoes of the Plaintiff, not ahead of other lienholders and unpaid providers.

There is no disarray in the courts as claimed by the Plan. While aspects of the extent of preemption have been, and continue to be, developing, this Supreme Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*, 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995), gave a clear signal to the courts that there was a limit to the scope of preemption intended by Congress under ERISA. The Seventh Circuit first followed the teaching of *New York State Conference* in *Blackburn v. Sundstrand*, 115 F.3d 493 (7th Cir. 1997). The Illinois Supreme Court, as well, in *Scholtens v. Schneider*, 173 Ill. 2d 375, 219 Ill. Dec. 490, 671 N.E. 2d 657 (1996). Those cases in the Seventh Circuit cited by the Plan, *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) and *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293 (7th Cir. 1993) were decided prior to *New York State Conference*. The 1991 case *McGee v. Humbrecht*, Nos. 91-2668, 91-2722 (E.D. La. Sept. 26, 1991), relied almost solely on *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990) in denying a Motion to Remand. It preceded *New York State Conference* and, therefore, is no evidence of discontinuity since. On close examination, those District Court cases cited as evidence of the allowance of jurisdiction in situations like this do not support the Plan's contention. *Wright v. Aetna Life Insurance Co.*, 110 F.3d 762 (11th Cir. 1997) was a separately filed Declaratory Judgment seeking interpretation of plan documents. It was filed in state court and removed. The court found that the Summary Plan Description provision on reimbursement was ambiguous, but that a signed reimbursement interpreted that provision. The issue of Federal Jurisdiction was

not raised or addressed in that opinion. There is no indication of a Motion to Remand. *Marshall v. Employers Health Insurance Co.*, Nos. 96-6063, 96-6112, 1997 WL 809997 (6th Cir. Dec. 30, 1997) was also a separately filed Declaratory Judgment seeking to interpret a provision of a plan document and, while the court noted it had jurisdiction, there is no indication that jurisdiction was questioned, that a Motion to Remand was filed. *Ryan by Capria-Ryan v. Federal Express Corp.*, 78 F.3d 123 (3d Cir. 1996) was also a separate Declaratory Judgment with no jurisdictional issue raised. *Cortez v. Michael Reese Health Plan, Inc.*, 980 F. Supp. 277 (N.D. Ill. 1997) was a separate Declaratory Judgment filed in state court where removal was contested. The District Court there relied on, *inter alia*, the District Court's decision in this case, *Speciale v. Seybold*, 951 F. Supp. 740 (N.D. Ill. 1996), since reversed by the Seventh Circuit. *Hartenbower v. Dent*, 963 F. Supp. 712 (N.D. Ill. 1997) involved removal of an entire negligence case based, again, in part on the District Court's opinion in *Speciale* before it was reversed. Neither opinion cited *Blackburn*. *Crump v. Wal-Mart Group Health Plan*, 925 F. Supp. 1214 (W.D. Ky. 1996) involved removal of a cross-claim to a plan's Petition to Intervene for subrogation filed in a state court action. The state court itself severed the cross-claim prior to removal. The cross-claim alleged ERISA violations by the plan and the remainder of the action, including the subrogation Petition, stayed in state court. Of note is the *Crump* court's statement that "no federal subject matter jurisdiction exists solely because an ERISA-authorized plan asserts its subrogation rights in a state tort action. (Citation omitted.)" 925 F. Supp. 1214 at 1217.

The Plan fails to show any widespread confusion or disagreement among the Circuits. Since *New York State Conference*, there has been a clear trend toward following the guidelines it articulated. Even in the Seventh Circuit, which had allowed removal, the decisions of *Blackburn* and *Speciale*

v. Seybold, 147 F.3d 612 (7th Cir. 1998) have set the rule for the District Courts in light of *New York State Conference. Speciale* was correctly decided and the Supreme Court need not re-assert the principles of *New York State Conference.*

ARGUMENT

I.

EXISTING LAW PROVIDES CLEAR DIRECTION ON THIS ISSUE OF REMOVAL

The approach to preemption fashioned by this Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*, 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995) has appropriately evolved from its initial broad sweep. As is natural, and as expected by Congress, the courts have considered the nature and effect of various contentions regarding issues sought to be included and excluded from ERISA's federal preemption. The courts have focused the jurisdiction to achieve the intent of Congress without unduly burdening themselves with tangential issues that are better handled in other forums. *New York State Conference* involved a hospital surcharge on patients insured by commercial insurers other than Blue Cross/Blue Shield. Its effect was to make it more expensive for ERISA plans and other insurers. While it specifically addressed conflict preemption, it made a thorough analysis of what "relates to" ERISA and what ERISA was meant to encompass. It teaches that there are many aspects of the law and economics which influence an ERISA plan and affects its costs and practices. These influences are laws of general applicability and have only a peripheral connection to a plan. They are not preempted by ERISA because they don't bind administrators to any particular scheme of coverage or regulate a choice of insurers or regulate the plan

itself. The Court, noting its own prior decision in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 108 S. Ct. 2182, 100 L. Ed. 2d 836 (1988), where the Court found that state law mechanisms which imposed garnishment judgments on plans, thus adding administrative costs, found that indirect sources of economic influence do not trigger preemption. Following the Court's decisions that state law mechanisms which affect the plans, but do so generally as other before the court, the *Blackburn* and *Speciale* appropriately found that those state law mechanisms do not raise a federal question and trigger the complete preemption required for removal.

II.

THE REMOVAL OF MOTIONS TO ADJUDICATE IS INCONSISTENT WITH THE PRINCIPLES OF REMOVAL

The jurisdictional approach urged by the Plan is intrusive, unnecessarily complex and requires the employment of needless fictions. As the Seventh Circuit noted in its *Speciale* opinion, quoting itself from *Blackburn*, "not even the most expansive reading of ERISA covers motor vehicle collisions, just because part of the recovery may inure to the benefit of a plan." 147 F.3d at 616. The same sentiment was voiced in *Crump* when the court discussed the importance of the cross-claim having been severed from the remainder of the action. The removal of a motion to adjudicate or allocate takes one piece of the underlying litigation and it frequently, as here, involves more than just the ERISA plan lienholder. The process of lien adjudication in state tort cases may affect a plan and its recovery in any specific case, but such exercises of ancillary jurisdiction affect all lienholders in a case. These motions do not interpret plan documents or declare ERISA rights. They are not a dispute

between the plan and beneficiary for benefits under the plan, nor an action to enforce rights under the plan. The Plan argues as if its right to subrogate was questioned. (Petition, p. 9.) Both Speciale's argument and the Seventh Circuit pointed out that there is no question raised here as to the Plan's right to subrogation, only which funds in the recovery are allocated to the Plan. No substantive reference to the plan documents is required. The district court cases cited by the Plan were never subject to appellate review and were all decided without the benefit of the Seventh Circuit's Blackburn opinion. The "declaratory judgment" approach they advocated ignores the well-pleaded complaint rule and tortures the "recasting" procedure beyond reason. The "recasting" idea is based on a translation of the claim from allegations of violations of state-imposed duties to allegations of violations of the duties under the comprehensive federal scheme which preempts the state claims. *Rice*. To "recharacterize" the motion as a declaratory judgment for rights under the plan changes the underlying judicial task from allocation to interpretation. As in *Rice*, the focus of the motion to adjudicate is not the plan, so preemption does not apply. In *Rice* the focus was the medical treatment of the plaintiff, here the focus is the settlement fund.

The contentions of the Plan regarding the "true purpose" of Speciale's Motion and arguments regarding the make-whole rule are based entirely on taking portions of the opinions and briefs out of context. The attempt at wordplay fails when the issues are reviewed in context. The Plan claims a subterfuge in attempting to avoid reimbursing the Plan, when what exists is an impossibility to reimburse the Plan in full and a need for allocation. The entire issue of the make-whole doctrine was so tangential to the core issues of the case that it was not even mentioned in the Seventh Circuit's opinion.

III.

THE SEVENTH CIRCUIT CORRECTLY DECIDED THE CASE AND PREVENTS THE CREATION OF SUPER-RIGHTS FOR ERISA SUBROGATION NEVER INTENDED BY CONGRESS

Any consideration of the propriety of the District Court's resolution of the matter and the Seventh Circuit's reversal must address the consequences of adopting the Plan's view that it was entitled to all of the settlement proceeds without consideration of the other lienholders. This was a concern of the District Court, but resolved in favor of the Plan. That result would have granted the Plan greater rights than Speciale had to the proceeds of the recovery. In a subrogation claim the subrogee steps into the shoes of the claimant, in a reimbursement claim the beneficiary pays back out of what she receives. In either situation, all other costs and liens are satisfied before the plaintiff has money. Congress did not include any specific subrogation legislation in ERISA. The plan is a contractual arrangement between the plan and its participants. The participants cannot give more to the plan than they have and cannot assign to the plan rights to recovery greater than those granted under state law. Accordingly, a plaintiff cannot assign her rights to proceeds that are never receivable by her. She is only entitled to proceeds remaining after the liens provided for by state law have been satisfied, by state law adjudication if necessary. A plan does not have the right to decide the law, just as a plan cannot, in its discretion, decide liability or make a plaintiff pay if she loses a case the plan felt should have been won.

CONCLUSION

For the reasons given above the Petition should be denied.

Respectfully submitted,

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